UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

WILLIAM STEFANIAK and JANICE STEFANIAK, Plaintiffs,	*	CIVIL ACTION NO. 05-11465-MLW
v.	*	
VOYAGER III, LLC, WATER TRANSPORTATION ALTERNATIVES, INC., Defendants.	*	

PLAINTIFF'S SUGGESTION OF DEATH REGARDING JANICE STEFANIAK AND JOINT REQUEST FOR AN EXTENSION OF DEADLINES

The Plaintiff, William Stefaniak, suggests upon the record, pursuant to Fed.R.Civ.P. 25(a), the death of his wife and co-Plaintiff, Janice Stefaniak, who died on December 10, 2006 during the pendency of this action and as a result of a rare and unexpected blood disease. A copy of her Death Certificate is attached hereto as Exhibit A.

Plaintiff shall, pursuant to Fed.R.Civ.P. 25(a)(1), move to substitute a party for his deceased wife as soon as her estate is in order and within the ninety days required by Rule 25(a).

PLAINTIFFS' LOCAL RULE 7.1(A)(2) CERTIFICATION

Insofar as LR7.1(A)(2) is applicable, I, David B. Kaplan, counsel for the Plaintiffs in the above entitled matter, state that I discussed Janice Stefaniak's death with the defense two days after her passing.

Respectfully submitted,
WILLIAM STEFANIAK and
JANICE STEFANIAK
By their attorney,

/s/ David B. Kaplan

DAVID B. KAPLAN, B.B.O. No. 258540
THE KAPLAN/BOND GROUP
88 Black Falcon Avenue, Suite 301
Boston, MA 02210
(617) 261-0080

Dated: January 18, 2007

I hereby certify that a true copy of the above document was served upon each attorney of record by ECF on January 18, 2007.

/s/ David B. Kaplan

The Commonwealth of Massachusetts

City of Worcester
Office of the City Clerk

429301

Copy of Record of Death

The below is a true copy of the original certificate placed on file in this office, and issued this date: DEC 18 2006

A Copy. *Attest:*

David J. Rushford
City Clerk

(INSTRUCTIONS ON REVERSE SIDE) FOR USE BY PHYSICIANS AND MEDICAL EXAMINERS

The Commonwealth of Massachusetts
STANDARD CERTIFICATE OF DEATH
REGISTRY OF VITAL RECORDS AND STATISTICS

REGISTERED NUMBER: 06 2759
STATE USE ONLY

STATE USE ONLY

DECEDENT

1 DECEDENT - NAME: FIRST: Janice; MIDDLE: R.; LAST: Stefaniak
2 SEX: F
3 DATE OF DEATH (Mo., Day, Yr.): December 10, 2006
4a PLACE OF DEATH (City/Town): Worcester
4b COUNTY OF DEATH: Worcester
4c HOSPITAL OR OTHER INSTITUTION - Name (If not hospital, give street and number): UMASS/MEMORIAL HEALTHCARE 55 LAKE AVE NORTH, WORCESTER, MA 01655
5 PLACE OF DEATH (Check only one): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
6 SOCIAL SECURITY NUMBER: 032-38-2667
7 IF US WAR VETERAN SPECIFY WAR: ----
8a WAS DECEDENT OF HISPANIC ORIGIN? (If yes, Specify Puerto Rican, Dominican, Cuban, etc.): [X] NO [ ] YES
8b RACE (e.g. White, Black, American Indian, etc.) (Specify): White
9 DECEDENT'S EDUCATION (Highest Grade Completed): Elementary Sec (0-12): 12; College (1-4, 5+):
10a AGE - Last Birthday (Yrs.): 51; MOS.: ; DAYS: ; HOURS: ; MINS:
10d DATE OF BIRTH (Mo., Day, Yr.): Nov. 21, 1955
11 BIRTHPLACE (City and State or Foreign Country): Fitchburg, Massachusetts
12 MARRIED, NEVER MARRIED WIDOWED OR DIVORCED: Married
13 LAST SPOUSE (If wife, give maiden name): William Stefaniak
14a USUAL OCCUPATION (Prior - If Retired): Secretary
14b KIND OF BUSINESS OR INDUSTRY: Education
15a RESIDENCE - NO. & ST., CITY/TOWN, COUNTY, STATE/COUNTRY: 12 North St., Leominster, Worcester, Massachusetts
15b ZIP CODE: 01453
16 FATHER - FULL NAME: Frank P. LeBlanc
17 STATE OF BIRTH (If not in US, name country): MA
18 MOTHER - NAME (GIVEN) (MAIDEN): Lorraine Gelinas
19 STATE OF BIRTH (If not in the US, name country): MA

INFORMANT

20 INFORMANT'S NAME: William Stefaniak
21 MAILING ADDRESS - NO. & ST., CITY/TOWN, STATE, ZIP CODE: 12 North St., Leominster, MA 01453
22 RELATIONSHIP: Husband

DISPOSITION

23 METHOD OF IMMEDIATE DISPOSITION: [X] BURIAL [ ] CREMATION [ ] ENTOMBMENT [ ] REMOVAL FROM STATE [ ] DONATION [ ] OTH. SPEC.
24 FUNERAL SERVICE LICENSEE OR OTHER DESIGNEE: Lawrence P. Brandon
25 LICENSE #: 6022
26a PLACE OF DISPOSITION (Name of Cemetery, Crematory or other): Saint Joseph Cemetery
26b LOCATION (City/Town, State): Fitchburg, Massachusetts
27 DATE OF DISPOSITION (Mo., Day, Yr.): Dec. 14, 2006
28a/b NAME AND ADDRESS OF FACILITY OR OTHER DESIGNEE: Brandon F.H. 305 Wanoosnoc Rd., Fitchburg, MA 01420

CERTIFIER

29 PART I - Enter the diseases, injuries, or complications that caused the death. Do not use only the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line (a through d) PRINT OR TYPE LEGIBLY.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	ACUTE STROKE	HOURS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST. DUE TO (OR AS A CONSEQUENCE OF) b.	THROMBOCYTOPENIA	DAYS
DUE TO (OR AS A CONSEQUENCE OF) c.	THROMBOTIC THROMBOCYTOPENIC PURPURA	WEEKS
DUE TO (OR AS A CONSEQUENCE OF) d.		

30 PART II - Other significant conditions contributing to death but not resulting in underlying cause given in Part I.: RESPIRATORY FAILURE
31 WAS AUTOPSY PERFORMED? (Yes or No): YES
32 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No): YES

33 MED. EXAM. NOTIFIED? (Yes or No): NO
34 MANNER OF DEATH: [X] NATURAL [ ] HOMICIDE [ ] COULD NOT BE DETERMINED [ ] ACCIDENT [ ] SUICIDE [ ] PENDING INVESTIGATION
35a DATE OF INJURY (Mo., Day, Yr.):
35b TIME OF INJURY:
35c INJURY AT WORK (Yes or No):
35d DESCRIBE HOW INJURY OCCURRED:
35e PLACE OF INJURY (At home, farm, street, factory, office bldg., etc.) Specify:
35f LOCATION (No. & St., City/Town, State):

To be Completed by CERTIFYING PHYSICIAN ONLY:
36a To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) stated. (Signature and Title): MD
36b DATE SIGNED (Mo., Day, Yr.): DECEMBER 10, 2006
36c HOUR OF DEATH: 6:40 A M
36d NAME OF ATTENDING PHYSICIAN IF NOT CERTIFIER: MARK MADISON M.D.

To be Completed by MEDICAL EXAMINER ONLY:
37a On the basis of examination and/or investigation in my opinion death occurred at the time, date, and place and due to the cause(s) stated. (Signature and Title):
37b DATE SIGNED (Mo., Day, Yr.):
37c HOUR OF DEATH:
37d PRONOUNCED DEAD (Mo., Day, Yr.):
37e PRONOUNCED DEAD (Hr):

38 NAME AND ADDRESS OF CERTIFYING PHYSICIAN OR MEDICAL EXAMINER (Type or Print): ELIZABETH FRAY M.D. 55 LAKE AVE. NO. WORCESTER, MA. 01655
39 LICENSE NO. OF CERTIFIER: 221545

40a WAS THERE A PRONOUNCEMENT FORM? (Yes or No): NO
40b IF YES, DATE PRONOUNCED:
40c IF YES, TIME PRONOUNCED:
40d NAME OF PRONOUNCER:
TITLE: [ ] R.N. [ ] P.A. [ ] N.P.

41 DATE BURIAL PERMIT ISSUED: DEC 18 2006; SIGNATURE AND OF HEALTH AGENT: Leonard J. Morse, M.D. Commissioner of Public Health
42 RECEIVED IN THE CITY/TOWN OF: WORCESTER; CLERK'S SIGNATURE:
43 DATE OF RECORD: DEC 18, 2006

Pronouncement of Death Form (R-302) on File: [ ]

PERMANENT BLACK INK ONLY

R-301-06